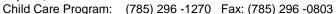
CCL. 009 Rev. 6/2015

Kansas Department of Health and Environment

Bureau of Family Health 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274



Website: www.kdheks.gov/kidsnet



CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS 16 YEARS OF AGE OR OLDER

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. Temporary substitutes in a licensed day care home or licensed group day care home are not required to obtain a health assessment. All persons over 16 years of age living in a Family Foster Home [K.A.R. 28-4-316(b)(1)] must have a health assessment. A Physician Assistant (PA) may complete the health assessment and must include the signature of the licensed physician authorizing the PA. The Health Assessment must be recorded on this KDHE form. Substitute forms are not accepted.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)										
Name of the facility (exactly as stated on the license)								License #		
Stree	t Address			Zip Code			County			
Chec	k type of child care	facility:								
	Licensed Day Car	e Home	☐ Child	Care Center	☐ Prescho	ool				
	Group Day Care Home			ol Age Program	Head Start Center					
Name of Provider/Staff			(14:11)				Date of Birth		/DD 2000	
		(First)		(Middle)	(Last)				(MM	/DD/YYYY)
Pleas 1. 2. 3. 4.	te check each quest Do you see a p Are you taking Have you had a Do you have ar interfere with the Do you have ar	physician re any medica any surgery ny handica ne care of c	gularly for an ation regularly in the past 3 oping conditional hildren?	y health condition? /? years? ons which might		<u>Yes</u>	<u>No</u>			
Heart High	aches Disease Blood Pressure Disease	<u>Yes</u> 	<u>No</u>	Cancer Diabetes Convulsions Mental Illness	<u>Yes</u> 	<u>No</u>		Alcoholism Arthritis Liver Disease Other	<u>Yes</u>	<u>No</u>
If Oth	er, Describe:									
	e reviewed the abov: (1 OR 2)	ove inform	nation and ha	PHYSICIAN, OR NUI	xaminatio	n and aı	ny tests	indicated. Sign o	ne of the	statements
Sig	nature of License	d Physicia	n or Nurse t	rained to perform h	ealth asse	ssment	s.	Date	(MM/DD/	YYYY)
2.	I found eviden children.	ice of phys	ical or mental	illness that would co	onflict with	he abilit	y to care	for the health, safe	ety or wel	fare of
Sig	gnature of License	ed Physicia	an or Nurse	trained to perform h	nealth ass	essmen	ts.	Date	(MM/DD/	YYYY)
				this form. on		(c	late) (Rep	eat test not needed u	nless there	e is exposure or
Test r	ead by Lice	ensed Physi	cian/Nurse Si	gnature or Health Dep	artment			 Date (MI	M/DD/YYY	Ύ)